DME Task Force Meeting
Medical Services Division
DME Related Questions
Friday, OCTOBER 13, 2017

Location: North Dakota State Capitol in Bismarck
Judicial Wing 2nd Floor – AV Room 210-212

Time: 1:00 p.m. to 3:00p.m.

Medical Services General Statement: The main purpose of the DME Task Force Meeting is to be a working group to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied cases. The Department's decisions are based on 42 CFR 440.230(d) and the North Dakota Administrative Code 75-02-02-08, which allows the Department to place appropriate limits on services based on such criteria as medical necessity or utilization control procedures.

Attendances : Tammy Holm - Medical Services
Sue Burns – Medical Services
Jennifer Sands – Medical Services
Nikki Lyons – Medical Services
Liz Rick – Sanford
Amber Holznagel-Leno -– Sanford
Kevin Holzer- Great Plains Bismarck
Brenda Schultz – Altru
Cheryl Nelson – Hanger Clinic
Dale Amen – Mid Dakota Clinic
Eric Johnson – Orthofix
Tammy Zachmeier – Medical Services
Sara Regner – Medical Services
Nicole Selzer – Medical Services
Bruce Mettin – Trinity
Cathy Dyke – Sanford
Tara Kahl – Hanger Clinic
Pat Greenfield – Med Quest
Barb Stockert – Sanford HCA
Jackie Schmalz – NuMotion
Anne Shaolman – Orthofix
Linda Steeple – Sleep Easy

All claims questions were pulled and sent over to the Claims Department. As soon as that Department has responded to them Tammy will get them posted on the DME Website. In the future if you have any questions that are in regards to claims it is best to address them to that department.

Provider Submitted Questions

1. Prior authorization denials. Paper copy is mailed to supplier and status states: "Denied" with comment that states: "Auth. /Access Restrictions". Provider must call the help line to find out the denial reason and is limited to 3 inquiries per phone call. If you have more than three inquiries, you must call back.

   When will the mailed copies be updated to state the denial reason under "Comment? When will we be able to go to MMIS to find the reason? The current process is not efficient in the use of time for the provider or for your department. See below:

   Results Calling 877-328-7098

   12:20 Called (Hold, 5th caller in line)

   12:40 Answered

   12:50 Finished call. Could only ask for 3 denials

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TOTAL TIME: 30 min.

Will MMIS be updated to show the reasons why an SA (PAR) is being denied? Staff currently have to call in to find this information...letters sent out do not have the denial reason on them & do not always receive them in a timely manner.

North Dakota Medicaid Response:

NDMA is working on having a text section added to the DME notification letter. Due to the main focus of the system being certified by CMS the Department is not able to give a date when this goal will be completed. We apologize for this inconvenience it is causing. The Department would like to remind providers that they can also email these questions also at mmisinfo@nd.gov

Discussion: Make sure that when you do email questions or concerns that you add ICN numbers or Service Authorization numbers.

2. Last year at our DME Task Force Meeting we were given the information that the NDMA program would consider no longer requiring priors for rental claims which have Medicare primary. Can we get an update on where you are in that process?

North Dakota Medicaid Response:

To clarify the Department shared that they have reviewed and identified 70 HCPC codes that would be removed from requiring service authorization. These changes are currently be revised and will need to be tested to make sure the changes are processing correctly. The Department will notify providers once this is completed and the fee schedule is updated accordingly.

3. Please look at the ND Provider Manual and the new Quick Links Coverage and Limitation Criteria and Policies for Bi-Pap's. There is a discrepancy in the conditions where coverage is allowed. The manual states AND but the Quick Links say OR. Please clarify?

The manual has never considered RDI as a qualifier for coverage of a Bi-Pap however, now the Quick Links state that either an AHI or RDI is allowed for coverage when it meets your criteria. Which is correct?

North Dakota Medicaid Response:

This typo was corrected and posted. To the Department's knowledge no SAs were denied based on this typo, but if there was please send Tammy Holm the SA so it can be reviewed. Thank you for bringing this to the Department's attention.

Discussion: AHI qualifier is the correct one to use.

4. 5 year ruling: Our understanding of the 5-year rule is, when there is a change in the patients' medical condition and it is well documented, a different piece of equipment would be allowed by most insurance carriers. What information does ND Medical Assistance expect to receive to have this considered?

   Providers have been denied with the reason that they should have anticipated and allowed for these changes when they provided the initial piece of equipment. It is inconceivable to expect that the initial provider should be able to "anticipate" all of the changes which could possibly occur during this 5-year period, just so the initial product would include all of these features or adaptations. Providers have received this as an explanation on denied Service Authorizations. Please explain.

   North Dakota Medicaid Response:

   The Department suggests providers have very good supporting documentation related to the member's change in condition that warrants the early replacement and why their current equipment no longer meets their medical needs.

   If the member is a child and growth is expected, the provider should consider equipment that can grow with them. For example, the specialized and/or customized wheelchairs as this would decrease the need for repeated costly replacement of existing equipment.

5. Could you provide a reference for modifier usage? Numerous times we have been asked to add or remove modifiers. We are referred to the fee schedule, however the requests from the NDMA staff do not line up with the fee schedule. Example: We are asked to add an NU to labor (K0739) as well as all catheters. Yet the fee schedule does not reflect these modifiers. Please clarify.

   North Dakota Medicaid Response:

   When submitting a service authorization or a claim, the appropriate modifier is required to insure correct payment. The purchase fee schedule requires the NU modifier and the rental fee schedule requires the RR modifier.

   The following modifiers are required as listed as follows:

   - **RB modifier is required to designate it is as a repair and requires a labor invoice to be submitted with the SA.**
   - **LT/RT to designate which side.**
   - **The Department has decided to utilize the RA to help make is easier to designate early replacement from a repair. A replacement is due to change in condition or lost, broken, etc. and requires a physician exam within 60 days of**

service, a prescription, an evaluation if applicable plus documentation to support the need for replacement. This will be effective Nov. 1st 2017. Without this modifier, the SA will be denied and will require the provider to submit correctly.

Discussion: Children outgrow wheelchairs you would use the RA not RD modifier. RA modifiers are used when no labor is involved. RD is used when labor is involved. Be in compliance with Medicare. Nov. 1st date put on hold to allow the department to look into further and post on the website.

6. Wound supplies - When a patient has more than one wound would it be possible to use modifiers instead of having to complete a PAR? Most other insurances use the Al, A2, etc. to identify the number of wounds and then pay accordingly.

North Dakota Medicaid Response:

The Department will need to check to see if the MMIS is able to be configured. If this is possible the Department will notify providers. Until then please continue the current process.

7. Miscellaneous HCPC's Claims/PARS...issue. These will pay at $0, as no allowed amount is indicated on the fee schedule so they need to be "manually adjusted" by NDMA staff.

There is also an issue with misc. codes that state the PAR (SA) is approved. If the claim is denied, and we call the provider help desk staff, they see the status as "pending" when they look at their system ...this issue has been referred to Tammy Holm, but we have not received a response to date.

North Dakota Medicaid Response:

This was an issue that was brought to the Department's attention that was reviewed by the SA staff and only SA's that had no paid claims for them could be "manually adjusted" by Tammy Holm. The Claims Department is aware of this and is working with IT to resolve the issue. Please contact them on the status of this issue and your claim(s).

8. PARS for Labor: Why are we getting denials for PARS for labor breakdown, when only 1 item is being billed with labor?

North Dakota Medicaid Response:

If a service authorization request is submitted without the required labor invoice that states why the item needs repair, it will be denied regardless of the number of units requested.

Discussion: labor invoices are needed as it shows the breakdowns of time spent on repairing items if billing for labor.

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9. Eligibility issue. When checking eligibility for DME coverage the patient must have a Fee for Service plan, a PCCM (Primary Care Case Mgmt.) plan or a QMB (Qualified Medicare Beneficiary) Plan to be covered; however, we have been told, on more than 1occasion, most recently on

   9/20/17 (REF# 387531) that a patient's profile can change on a day to day basis- the county case workers apparently can go in & update the NDMA system- Providers have no indication this may have occurred, until a claim is submitted and is denied for "no benefits". Is this issue being looked into?

   North Dakota Medicaid Response:

   The provider can check either by calling the AVRS (877-328-7098) or calling in to the call center for benefits. The Department reminds provider that they need check eligibility for the member prior to submitting service authorization and would encourage providers to recheck again prior to services being performed. This would also apply to DME items that do not require service authorization also.

This reminder can be found on page 14 of the DME Manual in the box states;

> **Note:** Prior approval to provide services does not include determination of the client's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient eligibility on the date of service.

10. ND Medical Assistance has the requirement for the client to see their physician within 60 days?

    It is unclear to us whether the 60 days is from the date of service provided, the date the order is written, or the SA start date? Tammy Holm will tell us that the 60 days has to be from the SA start date. What about items that do not require a SA? Please clarify.

    North Dakota Medicaid Response:

    For a service authorization, it would be from the requested start date and for items not requiring a service authorization would be the date of service.

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11. Would ND Medical Assistance ever consider following the Medicare requirement of the client seeing their physician within 6 months of the order?

    North Dakota Medicaid Response:

    North Dakota Medicaid has historically required member's to be seen by their prescribing physician 60 days before the date of service and will continue with this time frame for DME items.

12. What are your age requirements for B4160 and B4161 formulas? They are listed as a Pediatric formula but would you consider coverage for someone older if the medical record indicates this formula is medically necessary? We submitted documentation including chart notes for a client who is over the age of 18. The Service Authorization was approved but now claims are denying because the patient is not within the age requirements.

    There are no age requirements listed in the ND Medical Assistance manual. We would never have provided the product if the service authorization had not been approved.

    North Dakota Medicaid Response:

    B4160 and B4161 formulas are pediatric codes and using them for an adult is incorrect usage and was correctly denied. The member's physician can be asked to consider the list of covered age appropriate formulas for consideration.

    Discussion: B4158 and B4153 are the adult formula codes which are the same as the pediatric codes.

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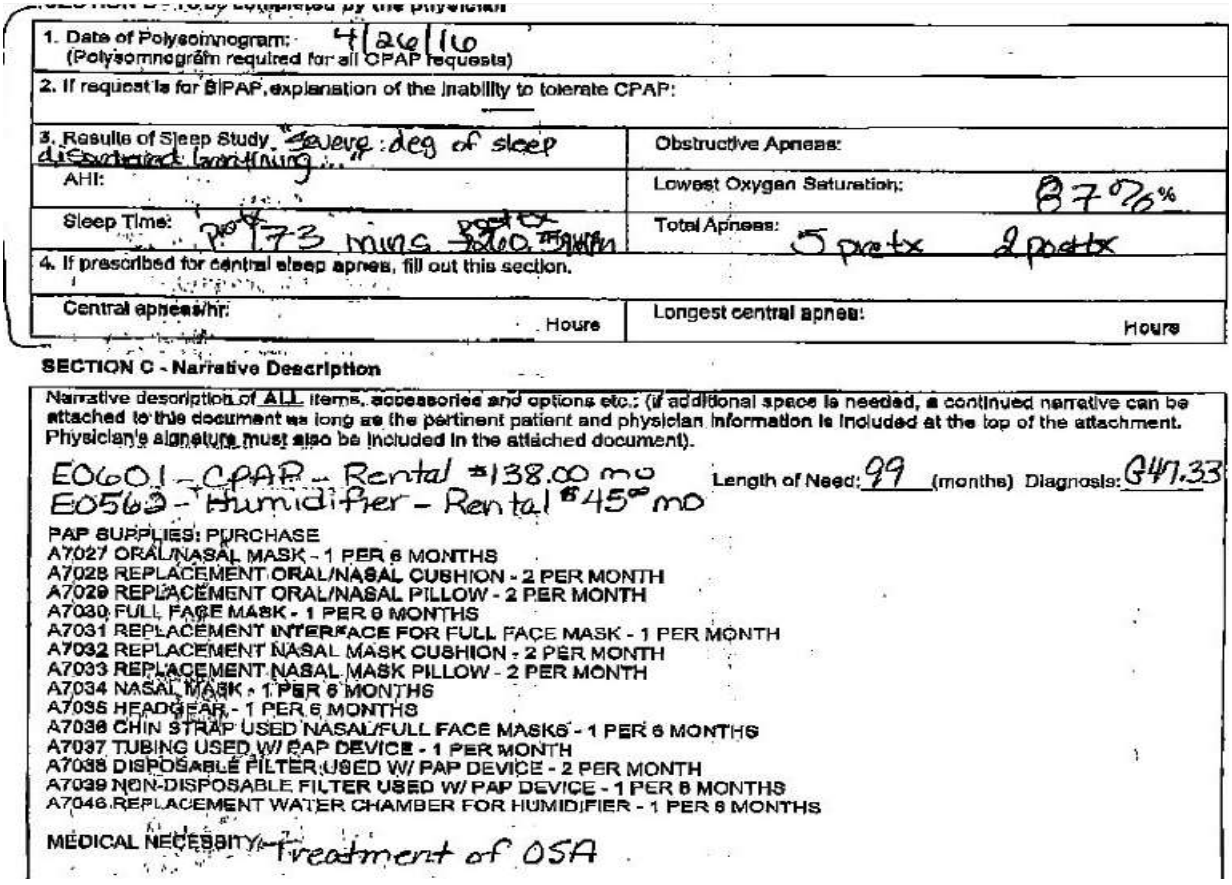
Additional Information:

- **The Department has been receiving CMNs that have been modified by the providers, see example below.**

  The purpose of the CMN is to be a quick reference guide to policy criteria (a user aid) not a replacement for required medical documentation or a required prescription. The CMN is not an all-inclusive guide for NDMA coverage criteria. Therefore is not a replacement for medical documentation.

  NDMA has been flexible in allowing physicians to utilize a CMN of their preference, which will at times require additional medical documentation to support medical necessity.

  NDMA is experiencing an increase in incomplete CMNs: sections not addressed, missing physician signature and/or not dated. This required information will result in the service authorization being denied, which delays the process.



1. Date of Polysomnogram: 4/26/16 (Polysomnogram required for all CPAP requests)
2. If request is for BIPAP, explanation of the inability to tolerate CPAP:
3. Results of Sleep Study: Severe deg of sleep disturbed breathing... | Obstructive Apneas:
   AHI: | Lowest Oxygen Saturation: 87%
   Sleep Time: P 173 mins | Total Apneas: 5 pre tx 2 post tx
4. If prescribed for central sleep apnea, fill out this section.
   Central apneas/hr: Hours | Longest central apnea: Hours

SECTION C - Narrative Description

Narrative description of ALL items, accessories and options etc.: (if additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included in the attached document).

E0601 - CPAP - Rental $138.00 mo
E0562 - Humidifier - Rental $45.00 mo
Length of Need: 99 (months) Diagnosis: G47.33

PAP SUPPLIES: PURCHASE
A7027 ORAL/NASAL MASK - 1 PER 6 MONTHS
A7028 REPLACEMENT ORAL/NASAL CUSHION - 2 PER MONTH
A7029 REPLACEMENT ORAL/NASAL PILLOW - 2 PER MONTH
A7030 FULL FACE MASK - 1 PER 6 MONTHS
A7031 REPLACEMENT INTERFACE FOR FULL FACE MASK - 1 PER MONTH
A7032 REPLACEMENT NASAL MASK CUSHION - 2 PER MONTH
A7033 REPLACEMENT NASAL MASK PILLOW - 2 PER MONTH
A7034 NASAL MASK - 1 PER 6 MONTHS
A7035 HEADGEAR - 1 PER 6 MONTHS
A7036 CHIN STRAP USED NASAL/FULL FACE MASKS - 1 PER 6 MONTHS
A7037 TUBING USED W/ PAP DEVICE - 1 PER MONTH
A7038 DISPOSABLE FILTER USED W/ PAP DEVICE - 2 PER MONTH
A7039 NON-DISPOSABLE FILTER USED W/ PAP DEVICE - 1 PER 6 MONTHS
A7046 REPLACEMENT WATER CHAMBER FOR HUMIDIFIER - 1 PER 6 MONTHS

MEDICAL NECESSITY: Treatment of OSA

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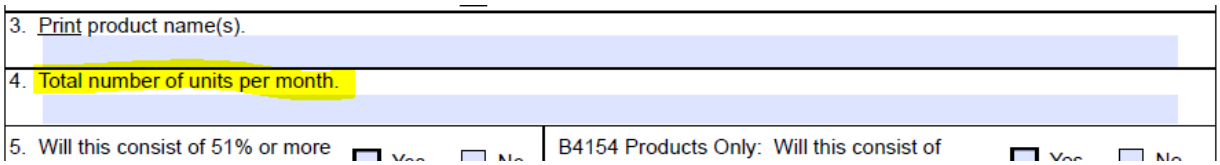
- **CMN's for enteral products must have line 4 units listed to prevent a denial.**



Units are per month. On the service auth. if the dates of service are for a year (12 months) the requested units need to be for 12 months to. For example; Dr. orders 450 units per month for a year. Take 12 months x 450 units per month = 5400 units. This is the total to be entered on the service auth. request.

- **PT, OT, Orthotist, or Prosthetist notes are supporting documents, but are not a substitute for the required Dr. Exam notes.**

- **What codes/reasons you will see when you check the status of your SA on the web portal.**

  A1 – Certified in total –all items requested were approved as requested

  A2 – Certified – Partial – not all items were approved

  A3 – Not Certified – SA denied

  A4 – Pended- waiting to be reviewed

  A6 – Modified – all items requested approved but not approved as requested. Example; labor units requested is 8 but only 6 was approved.

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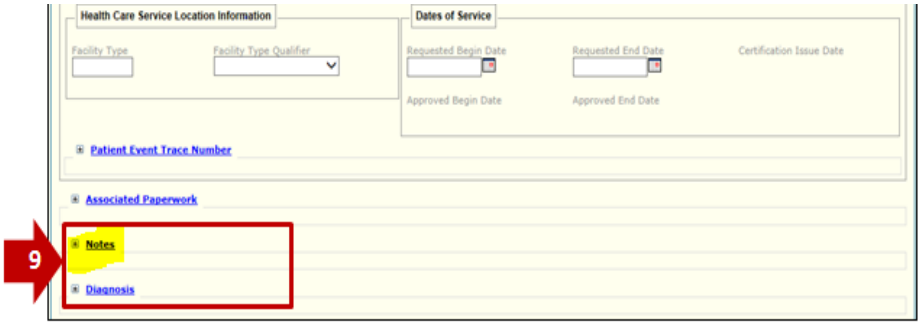
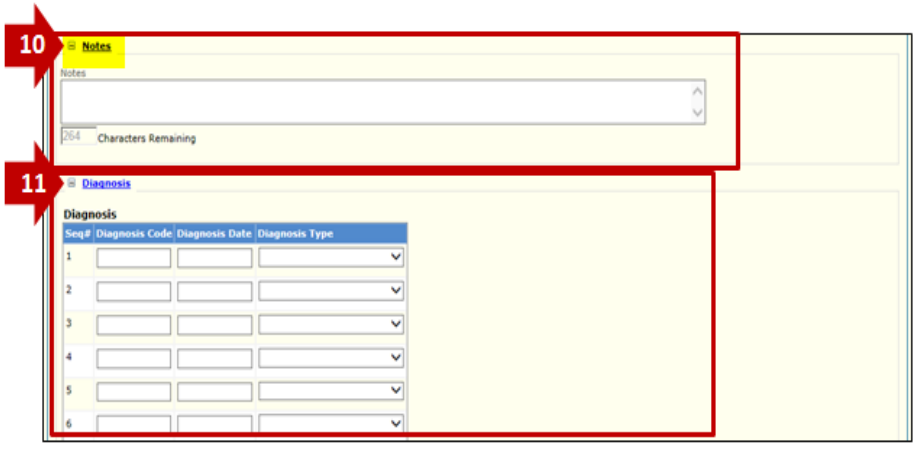
- **Please remember to include on the SA notes section (see yellow highlighted section below) equipment date of purchase, equipment purchased prior to enter to nursing home, insurance info., reason for early equipment replacement or any information the provider feels will assist during the review.**





9. **Notes** and **Diagnosis** are expandable sections that you use to provide additional information to support your request.

   Click **+** to open the **Notes** and **Diagnosis** sections.

10. Use **Notes** to provide any **required** information that you previously included on the paper SA form, including:
    - Equipment date of purchase
    - Equipment purchased prior to entering nursing home
    - All insurances, if Medicaid is not the primary insurer
    - Reasons for requesting early equipment replacement
    - PLUS, any information that will help the reviewer processing the SA

   After completing your notes, click **Save** at the bottom of the page/screen.

- **The Department reminds providers to check Medicaid Provider's Update web page for important updates regarding policy changes, billing and coding guidance etc.**

  http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-updates.html

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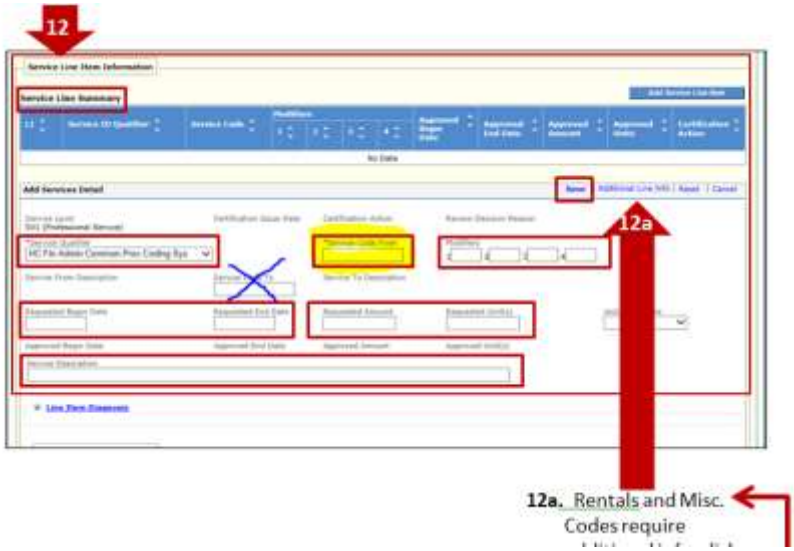
- **When entering information on the Service Line Item only the Service Code from is required. Please do not utilize the Service Code to as it is not necessary for DME requests.**



11. Use **Diagnosis** to enter the diagnoses related to the SA. After completing, click **Save** at the bottom of the page/screen.

12. **Service Line Item Information** section is already open and the following fields are required under **Add Services Detail**, including:

- **Service Qualifier**
- **Service Code From**
- **Modifiers** (e.g. RR for rental)
- **Requested Begin Date** and **Requested End Date**
- **Requested Amount** and/or **Requested Unit(s)**
- **Service Description** when SA uses a Misc. Code (e.g. K0108 used for items that require quantities greater than one)

- **PROVIDER DOCUMENATION RESPONSIBILITY**

A DME supplier is responsible to maintain all North Dakota Medicaid member records, which include the following:

1. **Current, original physician orders, coverage decisions are not based solely on the prescription;**

   The prescription must indicate:

   - **Date the prescription was written**
   - **Patient name (first and last name)**
   - **Date of Birth or Medicaid ID Number**
   - **Name of the item prescribed**
   - **Quantity of the item/supply ordered**
   - **Directions for use**
   - **Physician signature and signature date**
   - **The length of need.**

2. **A complete CMN and additional medical necessity information provided by the physician/practitioner.**

- **Failure to obtain a properly physician/practitioner signed, completed CMN is cause for denial/non-payment.**
- **Periodically, a CMN may be added to this list and providers will be notified via the Departments website under the Update Provider Link: http://www.nd.gov/dhs/services/medicalserv/medicaid/provider.html**

3. **Detailed record of item(s) provided to include brand name, model number, quantity, and proof of delivery; and**

4. **Approved prior authorization/service authorization; and**

   - **Failure to obtain when required is cause for a denial/non-payment.**

5. **Documentation supporting the member or member's caregiver was provided with manufacturer instructions, warranty information, service manual, and operating instructions**

   - **Documentation must coincide with other documentation provided by those involved with the member.**
   - **The provider must obtain the required documentation in a timely manner as described under each section above.**

❖ **Effective November 1st, 2017 all DME providers will be required to attach all required supporting documents to their SA requests. This option has been available since last April and has been greatly utilized by providers. It has proven to be very reliable and efficient which has aided greatly in decreasing denials for no information received.**

If the Department receives any attachments to link to a SA it will be returned to the provider with a memo stating the Department is no longer processing this requests and the provider will need to do this.

The link below is the DME webpage where the instructions on how to attach/link the required supporting documents directly to the SA.

http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html

❖ **SERVICE AUTHORIZATION (Prior Authorization)**

Under the North Dakota Medicaid program, certain covered services and equipment require prior approval to provision of the service(s) as a condition of reimbursement. A service authorization submitted by the DME Provider and its attached required supporting documents is reviewed solely for medical necessity, appropriateness of items requested, and location of service, if most cost-effective, and if in compliance with the Department's DME policy coverage criteria, prior to delivery of service.

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Prior approval from the Department only pertains to medical necessity of the items requested on the service authorization. It does *not* guarantee payment, member eligibility or prevent later recoupment of claims paid, during an audit, if all billing and document/documentation requirements are not fulfilled.

- **Effective November 1st, 2017 all DME Providers will be required to electronically attach all required supporting documents directly their web submitted service authorizations. This option has been available and successfully utilized by many providers since April of this year.**

  http://www.nd.gov/dhs/services/medicalserv/medicaid/provider-durable.html

Program Integrity

As a reminder Federal law requires state Medicaid Programs to cost avoid claims that have third party coverage. Providers must identify liable third party payers and bill the third party payers prior to billing Medicaid. Medicaid is the payer of last resort. The providers must obtain information about a recipient's health care coverage from the recipient, the recipient's representative, the county social service office, or through the information provided by the Medicaid remittance advice on the Explanation of Benefits.

Billing Medicaid and another third party for the same service at the same time is considered a violation under Medicaid rules. Medicaid is the payer of last resort and can only be billed after the third party has paid its legal liability.

The Department was granted approval from CMS a RAC Waiver effective for 2 years starting April 2017. So no RAC audits will be conducted until April 2019.

Announcement

The Department is considering possible meeting format options to achieve the original intent of the DME Task Force Meeting for all enrolled DME providers the opportunity to discuss current policy and to bring recommendations to the table for Medical Services to take into consideration. It is not meant to discuss individually denied service authorization or claims cases. With this in minded the Department asks providers to keep this in mind when preparing questions to submit for next year's meeting. Please email your policy related issues/recommendations to Tammy Holm at tamholm@nd.gov by the end of the business day September 14th, 2018. The Department will then determine the appropriate meeting format and notify providers accordingly.

As always please feel free to contact Tammy Holm anytime by email with policy questions or questions that the Call Center was not able assist when they occur via email at tamholm@nd.gov.

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The claims related questions were sent to the Claims department for response. Once they have completed them they will posted to the DME webpages for providers review.

Future Claims denials/questions needing assistance process is to first contacting the Call Center or emailing them mmisinfo@nd.gov. If you still have questions contact the Call Center supervisor Laura Holzworth at lholzworth@nd.gov.

The Department would like to thank providers for their continued services and dedication that they provide for our NDMA members.

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